ZERONA™ New Client Registration

Name: ______________________________ Home Phone: __________________ Cell: ____________________

Date of Birth: __________________ Emergency Contact: __________________ Phone: _________________

Address: ______________________________ City: ________________ State: ____________ Zip: ___________

Email: _________________________ How did you hear about us? ____________________________________

History: Please indicate if you have any of the following by circling **YES or NO.**

Yes No Diabetes - if yes, which type____
Yes No Insulin dependant
Yes No Active Infection
Yes No Implanted Medical Device: Pacemaker, Pain Pump, Deep Brain Stimulation, Other ___________________

Yes No Active Cancer within last 5 years ____
Yes No Cardiovascular Disease
Yes No Congestive heart failure
Yes No Congestive Obstructive Pulmonary Disease (COPD)
Yes No Congenital Anomaly - if yes, please describe____
Yes No Recent Heart palpitations
Yes No Recent Chest tightness / left shoulder or arm pain
Yes No Recent Cardiac Surgery,
Yes No Cosmetic Surgery - if yes, please list _______________________________________

Yes No Liposuction - if yes, what area(s) ____
Yes No Abdominoplasty
Yes No Stomach stapling
Yes No Gastric Bypass / Lap band surgery
Yes No Recent Gastro-Intestinal conditions
Yes No Recent Diarrhea / Constipation
Yes No Recent Abdominal pain / bleeding
Yes No Celiac Disease
Yes No Irritable Bowel Syndrome
Yes No Currently Pregnant
Yes No Currently Breast feeding
Yes No Liver Disease
Yes No Kidney Disease
Yes No Gall Bladder issues
Yes No Thyroid issues

Please list **ANY** medical conditions you have that are not mentioned above: ____________________________________

What medications are you currently taking? ____

What is your Alcohol Consumption: number of alcoholic drinks per week: ___________________________

How often do you exercise?____

By my signature below I verify that I have personally completed the above history form truthfully to the best of my knowledge.

__________________________________ __________________________________ __________________

Signature Printed Name Date

__________________________________ __________________________________ ___________________

Dr. Signature Date Approved/ Not Approved